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8 **BEFORE THE**  
9 **BOARD OF REGISTERED NURSING**  
10 **DEPARTMENT OF CONSUMER AFFAIRS**  
11 **STATE OF CALIFORNIA**

12 In the Matter of the Accusation Against:

13 **DIANNE VAUGHAN STEWART**  
14 **933 Buckingham Drive**  
15 **Windsor, CA 95492**  
16 **Registered Nurse License No. RN 458765**

17 Respondent.

Case No.

2010-337

**ACCUSATION**

18 Complainant alleges:

19 **PARTIES**

20 1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her  
21 official capacity as the Interim Executive Officer of the Board of Registered Nursing, Department  
22 of Consumer Affairs.

23 2. On or about August 31, 1990, the Board of Registered Nursing issued Registered  
24 Nurse License Number RN 458765 to Dianne Vaughan Stewart (Respondent). The Registered  
25 Nurse License was in full force and effect at all times relevant to the charges brought herein and  
26 will expire on September 30, 2010, unless renewed.

27 **JURISDICTION**

28 3. This Accusation is brought before the Board of Registered Nursing (Board),  
Department of Consumer Affairs, under the authority of the following laws. All section  
references are to the Business and Professions Code unless otherwise indicated.

4. Section 2750 of the Business and Professions Code ("Code") provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Section 2764 of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license.

6. Section 118, subdivision (b), of the Code provides that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary action during the period within which the license may be renewed, restored, reissued or reinstated.

7. Section 2761 of the Code states:

"The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

"(a) Unprofessional conduct, which includes, but is not limited to, the following:

• • •

8. Section 2762 of the Code states:

"In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do any of the following:

"(a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administer to himself or herself, or furnish or administer to another, any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022.

"(b) Use any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code, or any dangerous drug or dangerous device as defined in Section 4022, or alcoholic beverages, to an extent or in a manner dangerous or injurious to

1 himself or herself, any other person, or the public or to the extent that such use impairs his or her  
2 ability to conduct with safety to the public the practice authorized by his or her license.

3 "(c) Be convicted of a criminal offense involving the prescription, consumption, or  
4 self-administration of any of the substances described in subdivisions (a) and (b) of this section,  
5 or the possession of, or falsification of a record pertaining to, the substances described in  
6 subdivision (a) of this section, in which event the record of the conviction is conclusive evidence  
7 thereof.

8 "(d) Be committed or confined by a court of competent jurisdiction for intemperate use of  
9 or addiction to the use of any of the substances described in subdivisions (a) and (b) of this  
10 section, in which event the court order of commitment or confinement is prima facie evidence of  
11 such commitment or confinement.

12 "(e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any  
13 hospital, patient, or other record pertaining to the substances described in subdivision (a) of this  
14 section."

15 9. Section 125.3 of the Code provides, in pertinent part, that the Board may request the  
16 administrative law judge to direct a licentiate found to have committed a violation or violations of  
17 the licensing act to pay a sum not to exceed the reasonable costs of the investigation and  
18 enforcement of the case.

19 10. Health and Safety Code section 11173(a) states, in pertinent part, that no person shall  
20 obtain or attempt to obtain controlled substances, or procure or attempt to procure the  
21 administration of or prescription for controlled substances by fraud, deceit, misrepresentation or  
22 subterfuge.

## 23 DRUGS

24 11. Morphine is a Schedule II controlled substance as designated by Health and Safety  
25 Code section 11055(b)(1)(M), and a dangerous drug as designated by Code section 4022. It is  
26 used to treat moderate to severe pain.

12. Demerol is a brand of meperidine hydrochloride, a Schedule II controlled substance as designated by Health and Safety Code section 11055(c)(17) and is a dangerous drug per Code section 4022. It is used for moderate to severe pain.

#### FIRST CAUSE FOR DISCIPLINE

##### (ILLEGALLY OBTAIN OR POSSESS CONTROLLED SUBSTANCES)

13. Respondent is subject to disciplinary action under Code section 2761(a) on the grounds of unprofessional conduct, as defined by Code section 2762(a), in that while on duty as a registered nurse at Kaiser Permanente, Santa Rosa, California, Respondent illegally obtained and/or possessed controlled substances as follows:

##### Patient A:

a. On November 2, 2003 between 09:22 and 17:37, Respondent removed 275 mg of Demerol from the hospital Pyxis<sup>1</sup>. Respondent documented having administered 250 mg of the Demerol; however, there was no documentation of the remaining 25 mg being administered, nor was there documentation of wastage.

##### Patient B:

b. On November 6, 2003 at 17:54, Respondent removed 4 mg of Morphine from the hospital Pyxis. Respondent failed to document administration or wastage of the morphine, or account for its disposition.

##### Patient C:

c. On October 17, 2003 at 07:57, Respondent removed 4 mg of Morphine from the hospital Pyxis. Respondent failed to document administration or wastage of the morphine, or account for its disposition.

d. On October 17, 2003 at 08:35, Respondent removed 15 mg of Morphine from the hospital Pyxis. Respondent failed to document administration or wastage of the morphine, or account for its disposition.

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<sup>1</sup> Pyxis is a hospital computerized medication storage system.

1 e. On October 18, 2003 at 08:44, Respondent removed 15 mg of Morphine from the  
2 hospital Pyxis. Respondent failed to document administration or wastage of the morphine, or  
3 account for its disposition.

4 f. On October 18, 2003 at 18:55, Respondent removed 15 mg of Morphine from the  
5 hospital Pyxis. Respondent failed to document administration or wastage of the morphine, or  
6 account for its disposition.

7 g. On October 18, 2003 at 19:08, Respondent removed 2 mg of Morphine from the  
8 hospital Pyxis. Respondent failed to document administration or wastage of the morphine, or  
9 account for its disposition.

10 h. On October 19, 2003 at 08:48, Respondent removed 15 mg of Morphine from the  
11 hospital Pyxis. Respondent failed to document administration or wastage of the morphine, or  
12 account for its disposition.

13 i. On October 19, 2003 at 12:25, Respondent removed 2 mg of Morphine from the  
14 hospital Pyxis; at 12:26, Respondent removed 4 mg of Morphine. Respondent documented  
15 administration of 4 mg of the medication, but failed to document wastage or otherwise account  
16 for the administration of the remaining 2 mg.

17 j. On October 19, 2003 at 14:11, Respondent removed 4 mg of Morphine from the  
18 hospital Pyxis. Respondent failed to document administration or wastage of the morphine, or  
19 account for its disposition.

20 k. On October 19, 2003 at 17:46, Respondent removed 15 mg of Morphine from the  
21 hospital Pyxis. Respondent failed to document administration or wastage of the morphine, or  
22 account for its disposition.

23 l. On October 19, 2003 at 18:46, Respondent removed 4 mg of Morphine from the  
24 hospital Pyxis. Respondent failed to document administration or wastage of the morphine, or  
25 account for its disposition.

26 m. On October 19, 2003 at 18:46, Respondent removed 2 mg of Morphine from the  
27 hospital Pyxis. Respondent failed to document administration or wastage of the morphine, or  
28 account for its disposition.

1 SECOND CAUSE FOR DISCIPLINE  
2 (ILLEGAL USE OF CONTROLLED SUBSTANCES)

3 14. Respondent is subject to disciplinary action under Code section 2761(a) on the  
4 grounds of unprofessional conduct, as defined by Code section 2762(b), in that between October  
5 17, 2003 and November 6, 2003, at Kaiser Permanente Santa Rosa, California, Respondent used  
6 Demerol and/or Morphine, controlled substances, to an extent or in a manner dangerous or  
7 injurious to herself and/or others.

8 THIRD CAUSE FOR DISCIPLINE  
9 (FALSIFY, OR MAKE GROSSLY INCORRECT, GROSSLY INCONSISTENT, OR  
10 UNINTELLIGIBLE ENTRIES IN ANY PATIENT RECORD)

11 15. Respondent is subject to disciplinary action under Code section 2761(a) on the  
12 grounds of unprofessional conduct, as defined by Code section 2762(e), in that while on duty as a  
13 registered nurse at Kaiser Permanente, Santa Rosa, California, Respondent falsified, made grossly  
14 incorrect, grossly inconsistent, or unintelligible entries in hospital and patient records, as alleged  
15 above in paragraphs 13.a. through 13.m.

16 FOURTH CAUSE FOR DISCIPLINE  
17 (UNPROFESSIONAL CONDUCT)

18 16. Respondent is subject to disciplinary action under section 2761(a) in that she acted  
19 unprofessionally as alleged above in paragraphs 13.a. through 13.m., 14 and 15.  
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21 PRAYER

22 WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged,  
23 and that following the hearing, the Board of Registered Nursing issue a decision:

24 1. Revoking or suspending Registered Nurse License Number RN 458765, issued to  
25 Dianne Vaughan Stewart.

26 2. Ordering Dianne Vaughan Stewart to pay the Board of Registered Nursing the  
27 reasonable costs of the investigation and enforcement of this case, pursuant to Business and  
28 Professions Code section 125.3;

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3. Taking such other and further action as deemed necessary and proper.

DATED: 1/14/10

*Louise R. Bailey*  
LOUISE R. BAILEY, M.ED., RN  
Interim Executive Officer  
Board of Registered Nursing  
Department of Consumer Affairs  
State of California  
*Complainant*

SF2009405636